The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call us at (855) 827-4448. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (855) 827-4448 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0 – Individual or $0 – Family	See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Specialist Visit, Preventive Care/Screening/Immunization, Laboratory Outpatient and Professional Services, X-rays and Diagnostic Imaging, Outpatient Facility Fee, Outpatient Surgery Physician/Surgical Services, Emergency Room Services, Urgent Care Centers or Facilities, Outpatient - Mental/Behavioral Health Services Office, Prenatal and Postnatal Care, Child - Routine Eye Exam, Child - Eye Glasses, Child - Dental Check-Up	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,500 – Individual or $13,000 – Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.brighthealthcare.com/search or call (855) 827-4448 for a list of network	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance

* For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2022_COCs/COC_44522_ADV_20220101.pdf

	providers.	billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge for first 2 visit(s) then $20	Not Covered	Telehealth services are available. Refer to Your Schedule of Benefits to determine what you will pay.
	Specialist visit	$40	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive, then check what Your plan will pay for and what Your cost will be.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: $50 X-ray: $100	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20%	Not Covered	Services require Prior Authorization.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.brighthealthcare.com	Preferred generic drugs	$0/$15	Not Covered	Preventive Care medications are provided at $0 cost to You, regardless of tier. Covers up to a 90-day supply (retail prescription); 31-90 day supply (mail order prescription). Copays shown reflect the cost per retail prescription.
	Preferred brand drugs and Non-preferred generics	$50	Not Covered	
	Non-preferred brand drugs and Non-preferred generics	$125	Not Covered	
	Specialty drugs	20%	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200	Not Covered	Services require Prior Authorization.
	Physician/surgeon fees	$50	Not Covered	Services require Prior Authorization.
If you need immediate medical attention	Emergency room care	$500	$500	This cost does not apply if You are admitted directly to the hospital for inpatient services.
	Emergency medical transportation	20%	20%	None
	Urgent care	$50	$50	None

* For more information about limitations and exceptions, see the plan or policy document at https://cdn1.brighthealthplan.com/docs/2022_COCs/COC_44522_ADV_20220101.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	Not Covered	Services require Prior Authorization.
	Physician/surgeon fees	20%	Not Covered	Services require Prior Authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0	Not Covered	Services require Prior Authorization.
	Inpatient services	20%	Not Covered	Services require Prior Authorization.
If you are pregnant	Office visits	$0	Not Covered	None
	Childbirth/delivery professional services	20%	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require Prior Authorization. 48 hours for vaginal birth; 96 hours for cesarean delivery
	Childbirth/delivery facility services	20%	Not Covered	
If you need help recovering or have other special needs	Home health care	20%	Not Covered	None
	Rehabilitation services	20%	Not Covered	Limited to 60 Visit(s) per year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization.
	Habilitation services	20%	Not Covered	Limited to 60 Visit(s) per year. Visits combined for physical, occupational, and speech therapy. Services require Prior Authorization.
	Skilled nursing center	20%	Not Covered	None
	Durable medical equipment	20%	Not Covered	Services require Prior Authorization.
	Hospice services	20%	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$0	Not Covered	Limited to 1 eye exam per calendar year, through the end of the month in which the dependent child turns 19.
	Children's glasses	$0	Not Covered	Limited to 1 pair of glasses, including standard frames and standard lenses or a one-year supply of contact lenses, per calendar year, through the end of the month in which the dependent child turns 19.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental checkups	$0	Not Covered	Includes diagnostic and preventive services through the end of the month in which the dependent child turns 19. Refer to the policy for covered services and limitations.

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
Acupuncture	Cosmetic Surgery	Long-Term Care
Non-emergency care when traveling outside the U.S.	Routine Foot Care	Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Abortion	Bariatric Surgery	Chiropractic Care
Dental Care (Adults)	Hearing Aids	Infertility Treatment
Private-Duty Nursing	Routine Eye Care (Adults)	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact the Illinois Department of Insurance at 1-877-527-9431. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact us at (855) 827-4448.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Bright HealthCare at www.brighthealthcare.com or contact the Illinois Department of Insurance at 1-877-527-9431.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al (855) 827-4448.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 827-4448.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (855) 827-4448.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (855) 827-4448.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $0
- Specialist copayment $40
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$1900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2760**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $0
- Specialist copayment $40
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic test (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $0
- Specialist copayment $40
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Bright HealthCare

Schedule of Benefits
Adult Dental Coverage
From 01/01/2022 through 12/31/2022

COVERED SERVICES	IN-NETWORK PLAN PAYS	OUT-OF- NETWORK PLAN PAYS
TYPE I, DIAGNOSTIC & PREVENTIVE SERVICES Oral Exams, Cleanings, Fluoride, X-rays (Full Mouth, Panoramic Image Bitewings, and Diagnostic X-rays), Teledentistry	100%	Not Covered
TYPE II, BASIC BENEFITS Fillings (Amalgam, Composite) Protective Restoration, Non-Surgical Periodontal Services (Scaling & Root Planing, Periodontal Maintenance, Full Mouth Debridement), Palliative Treatment, Consultation	70%	Not Covered
TYPE III, MAJOR BENEFITS	Not Covered	Not Covered
TYPE IV, ORTHODONTIA	Not Covered	Not Covered
Calendar Year Maximum	$1,000 per person	

Fees are based on contracted fees for in-network dentists. Reimbursement is paid on Liberty Dental Plan's contract allowances and not necessarily the dentist's actual fees.

This document provides a summary of the plan's benefits only. For a complete description of benefits, limitations and exclusions, refer to the plan's documents.

Dental deductible and maximums do not accumulate against the medical plan deductibles and maximums.

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Important:

If a Member decides to receive Dental Services that are not covered under this Agreement, the contracted dentist may charge the Member his or her usual and customary rate for those services. Prior to providing a Member with Dental Services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. For more information about the Dental Services that are covered under this Agreement, please call customer service at 1-855-827-4448.

This Agreement covers the dental services for Members when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for a Member's dental condition, the Plan will cover the least expensive treatment.

Pretreatment Estimate:

A pretreatment estimate is a valuable tool for You and Your Member. It gives You and the Member an idea of what the Member's Out-of-Pocket costs will be. This allows You and Your Member to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontal, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but not required for a Member to get benefits for Covered Services. A pretreatment estimate does not authorize treatment or determine its Medical Necessity, and does not guarantee benefits. The estimate will be based on a Member's current eligibility and the Agreement benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to Us at the time of the completed dental care service(s). Sending in other claims or changes to a Member's eligibility or to the Agreement may affect our final payment.

Members can ask their dentist to send pretreatment estimate on their behalf, or send it directly to Us. Please include the procedure codes for the services to be performed for a Member. Pretreatment estimate requests can be sent to Us. If a Member has questions on where to send the estimate, call Us at the number on the back of their ID card.

LIBERTY Dental Plan Corporation
PO Box 26110 Irvine, CA 92799-6110
Member Services: 855-827-4448

Bright HealthCare

Schedule of Benefits
Adult Vision Coverage
From 01/01/2022 through 12/31/2022

Vision Care Services	Member Cost In-Network
Exam with Dilation as Necessary	$10 Copay
Retinal Imaging Benefit	Up to $39
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130
Standard Plastic Lenses Single Vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens (If a member seeks Standard Plastic Lenses in AK, CA, HI, OR, WA, Group Contracted Rate is $15 higher)	 $25 Copay $25 Copay $25 Copay $25 Copay $90 Copay See Fixed Premium Progressive price list
Lens Options: UV Treatment Tint (Solid and Gradient) Standard Plastic Scratch Coating Standard Polycarbonate – Adults Standard Polycarbonate – Kids under 19 Standard Anti-Reflective Coating Polarized Other Add-Ons	 $15 Copay $15 Copay $15 Copay $40 Copay $40 Copay $45 Copay 20% off Retail Price 20% off Retail Price
Contact Lenses *(Contact lens allowance includes materials only)* Conventional Disposable Medically Necessary	 $0 Copay; $130 allowance, 15% off balance over $130 $0 Copay; $130 allowance, plus balance over $130 $0 Copay, Paid-in-Full
Laser Vision Correction Lasik or PRK from U.S. Laser Network	 15% off Retail Price or 5% off promotional price
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.
Frequency: Examination Lenses or Contact Lenses Frame	 Once every 12 months Once every 12 months Once every 12 months

Bright HealthCare

Schedule of Benefits
Adult Vision Coverage
From 01/01/2022 through 12/31/2022

Progressive Price List*	Member Cost In-Network (includes Lens Copay)
Standard Progressive	$90 copay
Premium Progressives as Follows: Tier 1 Tier 2 Tier 3 Tier 4	 $110 Copay $120 Copay $135 Copay $90 copay; 80% of charge less $120 Allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows: Tier 1 Tier 2 Tier 3	 $57 $68 80% of charge
Other Add-ons Price List	**Member Cost In-Network**
Photochromic (Plastic)	$75
Polarized	80% of charge

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

For a current listing of brands by tier, go to:
http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf

Bright HealthCare's Adult Vision Plan is administered by EyeMed.